Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $6,216.27 for date of service, 8/22/01.

   b. The request was received on 8/13/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Example EOBs from other Insurance Carriers
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. HCFA(s)
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Medical Records
   e. Methodology
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 9/19/02. Per Rule 133.307 (g) (4), the Carrier representative signed for the copy on 9/20/02. The response from the insurance carrier was received in the Division on 10/02/02. Therefore, the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 9/12/02

"….We are appealing the amount disallowed on the above mention [sic] claim. These charges are for **FACILITY FEES**, not professional fees. We feel that 8% paid on a trigger finger release on the right long finger is not fair or reasonable. We feel that Kemper should reimburse us more appropriately as $510.98 does not cover our costs to perform this surgery….Even though there is no real definition in the TWCC rules defining 'reasonable and necessary', we feel our medical services fees are 'fair and reasonable as outlined in the Texas Labor Code. Our facility's methodology is to bill only the supplies, medications, equipment, operating room and recovery room time that were used during the surgery. The total charges are as ***individual*** as the patients we are treating. It is not fair nor reasonable to bill a flat or a per diem rate for a surgery, as the patient may not use certain supplies and medications, or may not spend the same amount of time in the operating room or recovery room and still get charged for something that was not consumed…. Recent SOAH decisions indicate that examples of EOBs of what other insurance carriers are willing to pay is not evidence of effective medical cost control and is not evidence of amounts paid on behalf of managed care patients of ASCs or on behalf of other non-workers' compensation patients with equivalent standard of living. The rationale of why we have enclosed the many examples of EOBS serve several different purposes other than the reasons addressed in the SOAH decisions. First, it backs up our claim that other insurance carriers are in fact paying 85% - 100% of our billed charges. Second, contrary to what the ALJ indicates, the examples do show that we do achieve medical cost control, not only by not changing the fees we charge for the use of our facility and equipment as explained above. It also shows that we do in fact bill everyone in the same manner no matter if it is a workers' compensation claim and it is a TWCC subscriber or a workers' compensation claim that is not a TWCC subscriber, if it is an occupational policy, or a group claim. This information not only backs up our statements, it also proves that (Requestor) does indeed follow the Texas Labor Code and the TWCC rules. Last, but not least, the decisions were ruled against another facility that has nothing to do with us and cannot be compared, as we were not the ones on trial…."

2. Respondent: Letter dated 10/02/02

"This medical dispute concerns the (Provider's) entitlement to additional reimbursement for facility charges associated with a trigger finger release performed on (Claimant) on August 22, 2001. The surgery took an hour to perform. (Claimant) stayed at (Provider's facility) approximately four hours and ten minutes….(Provider) has provided copies of charges it has made to other Carriers. (Provider) has also provided explanations of benefits (EOBs) apparently showing that these Carrier's [sic] paid all or most of (Provider's) charges. The fact that the charges in these cases are similar to the charges in this case does not establish that (Provider's) charges are fair and reasonable…. To comply with Rule 133.304 and avoid inconsistent reimbursement, (Carrier) through (Third Party Administrator [TPA]), has developed a methodology to reimburse ASC's in a fair and reasonable manner…(Provider) has failed to establish that it is entitled to additional reimbursement."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8/22/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $6,727.25 for services rendered on 8/22/01.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $510.98 for services rendered on 8/22/01.

5. The Carrier's EOBs denied any additional reimbursement as "705 – M–No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area; 620 – O-Denial after reconsideration/A denial letter has been sent to the provider for this service."

6. The amount in dispute is $6,216.27 for services rendered on the date of service in dispute above.

7. The facility provided O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy, anesthesia equipment, and Recovery Room services.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center for a trigger release on the right long finger. The provider has submitted several examples of other Carrier's EOBs for charges billed for a similar procedure. However, the carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their payment methodology.

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;"

(TPA's) methodology incorporates information from 6 states, which have adopted a system to determine ASC charges based on intensity levels. The range is from 1 (low) to 8 (high), which is determined based on where the CPT Code falls in the HCFA intensity grouper list. (TPA) averaged the payments in each level for the 6 states and designated this as the base fee for each intensity level. (TPA) also takes into account local economic factors and applies HCFA' s wage index factor to the base fees. If the specific area is not addressed in the wage index, (TPA) uses the state average.

The TPA sums up its methodology, indicating it generates fair and reasonable fees utilizing a well accepted intensity grouper and average prevailing usual and customary reimbursement from a geographically diverse set of workers' compensation fee schedules. There is no discounting from mean payments; a local economic adjustor is applied to the reimbursement; and additional payments are made for extraordinary supplies and lab testing.

The Respondent included attachments to further reflect its methodology. Attachment A indicates grouper numbers, CPT codes, and range of charges. Attachment B compares Medicare rates for ASC bills with states that have a similar payment schedule. Attachment C is the wage index used to take into account geographical differences.

The TPA provided a list of Texas ASC centers (bills processed in May and June 2000) that have been paid based on their methodology. The TPA also indicates that it has canvassed other payers in the system who reimburse on the average of 110% to 140% of Medicare allowable rates and even though the TPA does not use Medicare, it compares favorably because it pays an average of 150% of Medicare.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of what is fair and reasonable. As the requestor, the health care provider has to provide documentation that "…discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." Pursuant to TWCC Rule 133.307 (g) (3) (D), the requestor has submitted documentation in the form of example EOBs. Respondent has provided their methodology, which conforms to the additional criteria of Sec. 413.011 (d).

The law or rules are not specific in the amount of evidence that has to be submitted for a determination of what is a fair and reasonable rate. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. In this case, the

Requestor has failed to support their position that the amount billed is fair and reasonable and the Respondent has submitted enough information to support the argument that the amount reimbursed represents a fair and reasonable reimbursement. Therefore, **no additional** reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D); and (j) (1) (F).

The above Findings and Decision are hereby issued this 16th day of April 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division